BHSF Form 148-W
Rev. 05/12
Prior Issue Obsolete

Notification of Admission, Status Change, or Decertification/Discharge for HCBS Waiver

Support Coordinator Agency:		Medicaid Provider #:
Support Coordinator Address:		Region #:
Telephone #:	Fax #:	Parish:
Waiver: ☐ NOW ☐ NOW Fund ☐ Children's Choice ☐ ADHC ☐ Supports Waiver ☐ ROW ☐ Community Choices		

I. PARTICIPANT/MEDICAID ELIGIBLE INFORMATION

☐ Change in Personal Information

A. Participant's Name:	SSN:	Parish:
Address:		Telephone #:
Sex: : ☐M ☐F	DOB:	Marital Status: ☐Single ☐Married ☐Widow ☐Divorced/Separated
Medicare #:	Medicaid Eligible? ☐Yes ☐No	Medicaid#:
B. Personal Representative/Curator:		Relationship:
Address:		E-mail:
Home Phone:	Cell Phone:	Daytime Phone:

II. ADMISSION INFORMATION

A. ☐ Program Linkage Date:

1. Residence Prior to Admission to HCBS: (Specify from Section V):
2. Intended Admission Payment Source: ☐Medicaid ☐ Other (specify):

B. ☐Received as a transfer on date: from Region

C. ☐Received as a transition from the Waiver to the Waiver, on (date):

D. ☐ Facility resident approved for waiver services for transitioning. Effective (date)

III. STATUS CHANGE (Includes Transfers)

A. ☐ Temporary facility/Acute Care placement. NOT discharged from waiver. Admission date:
Temporary Placement (Facility/Hospital Name): _____
Facility Type: ☐Acute Care/Hospital ☐Nursing Facility ☐ Public ICF/DD ☐ Private ICF/DD ☐ Other: _____
If transferred from acute care hospital to temporary placement in LTC facility, indicate acute care hospital admit date:_____

B. ☐Returned to waiver from temporary facility or Acute Care placement, effective date:

C. ☐Transferred from Region: to Region: on date:

D. ☐Transitioned from the Waiver to the Waiver on date:

E. ☐Transferred from Agency to Agency on (date):

F. ☐ Facility resident discharged. Transitioned to waiver. Date:

IV. DISCHARGE or DEATH NOTICE (Permanent Discharges Only)

A. Discharged to (from Section V, include address): _____
Reason for Discharge: _____
Date of Discharge authorized by ☐OAAS ☐ OCDD Regional Office: _____

B. Date of Death:

V. SOURCE OF ADMISSION or DISCHARGE DESTINATION

1. Own home (specify address)
2. Apartment (specify address)
3. Family member's home (specify name & address)
4. Friend's home (specify name & address)
5. A Nursing Facility (specify name & address)
6. General hospital (specify name & address)
7. Psychiatric hospital/unit (specify name & address)
8. Rehabilitation hospital (specify name & address)
9. A residential program or group home (specify name & address)
10. An ICF/DD (specify name & address)
11. A Medicare distinct unit (specify name & address)
12. Hospice (specify name & address)
13. Incarceration (jail/prison/detention center)
14. Transitioning from Nursing Facility
15. Other (specify)

_____ _____
Support Coordination Agency Representative **Date**

_____ _____
Approving DHH Waiver Representative (if applicable) **Date**